

AUTHORIZATION FOR TREATMENT

As a parent or legal guardian of _____, I
(child's name)
give the Mexico Central School District permission to care for my child at school in
accordance with the District's established medical and first aid guidelines. I grant the
school nurse permission to exchange medical information about my child with my child's
health care provider and current teachers as necessary.

This consent is valid indefinitely from this date unless revoked by the parent or
guardian.

Parent/ Guardian Signature _____ Date _____